

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0044024</u></p> <p><b>Facility Name:</b> <u>SAINT CLARE HOME</u></p> <p><b>Address:</b> <u>5533 N. GALENA ROAD</u> <u>PEORIA HEIGHTS</u> <u>61614</u>          Number City Zip Code</p> <p><b>County:</b> <u>PEORIA</u></p> <p><b>Telephone Number:</b> <u>( 309 ) 682-5428</u> <b>Fax # ( )</b></p> <p><b>IDPA ID Number:</b> <u>370813229001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/01/98</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>CRAIG L. ATER</u> <b>Telephone Number:</b> <u>( )</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2001</u> to <u>09/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 824" rowspan="2"><b>Officer or Administrator of Provider</b></td> <td data-bbox="1283 678 1921 711">(Signed) _____</td> </tr> <tr> <td data-bbox="1283 711 1921 743">(Type or Print Name) <u>Pete Bolt III</u></td> </tr> <tr> <td data-bbox="1150 824 1283 889" rowspan="2"></td> <td data-bbox="1283 824 1921 857">(Title) <u>Administrator</u></td> </tr> <tr> <td data-bbox="1283 857 1921 889"></td> </tr> <tr> <td data-bbox="1150 889 1283 1040" rowspan="4"><b>Paid Preparer</b></td> <td data-bbox="1283 889 1921 922">(Signed) _____</td> </tr> <tr> <td data-bbox="1283 922 1921 954">(Date) _____</td> </tr> <tr> <td data-bbox="1283 954 1921 987">(Print Name and Title) <u>CRAIG L. ATER</u></td> </tr> <tr> <td data-bbox="1283 987 1921 1019">(Firm Name &amp; Address) <u>Heritage Enterprises</u></td> </tr> <tr> <td data-bbox="1150 1040 1283 1122" rowspan="2"></td> <td data-bbox="1283 1019 1921 1052">(Telephone) <u>( 309 ) 823-7135</u> <b>Fax # ( )</b></td> </tr> <tr> <td data-bbox="1283 1052 1921 1122"> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Pete Bolt III</u>		(Title) <u>Administrator</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) <u>CRAIG L. ATER</u>	(Firm Name & Address) <u>Heritage Enterprises</u>		(Telephone) <u>( 309 ) 823-7135</u> <b>Fax # ( )</b>	<p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number SAINT CLARE HOME# 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5	<u>4</u>	Sheltered Care (SC)	<u>4</u>	<u>1,460</u>	5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,041</u>	<u>10,892</u>	<u>2,057</u>	<u>33,990</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,041</u>	<u>10,892</u>	<u>2,057</u>	<u>33,990</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 95.02%

D. How many bed-hold days during this year were paid by Public Aid?

403 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/01/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/01/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided 2,057Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning: 10/01/2001

Ending: 09/30/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	218,866	23,037		241,903		241,903		241,903		1
2	Food Purchase		156,398		156,398		156,398		156,398		2
3	Housekeeping	113,551	12,433		125,984		125,984		125,984		3
4	Laundry	35,349	13,242		48,591		48,591		48,591		4
5	Heat and Other Utilities			94,834	94,834		94,834		94,834		5
6	Maintenance	62,359	48,232	32,173	142,764		142,764		142,764		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	430,125	253,342	127,007	810,474		810,474		810,474		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,295,533	115,837	249,459	1,660,829		1,660,829		1,660,829		10
10a	Therapy		91,715	158,073	249,788	(97,156)	152,632		152,632		10a
11	Activities	55,855	4,042	355	60,252		60,252		60,252		11
12	Social Services	27,112	19	2,700	29,831		29,831		29,831		12
13	Nurse Aide Training	879			879		879		879		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,379,379	211,613	414,187	2,005,179	(97,156)	1,908,023		1,908,023		16
	<b>C. General Administration</b>										
17	Administrative	54,469			54,469		54,469		54,469		17
18	Directors Fees										18
19	Professional Services			269,740	269,740		269,740	(1,237)	268,503		19
20	Dues, Fees, Subscriptions & Promotions			75,151	75,151	(51,465)	23,686	(10,689)	12,997		20
21	Clerical & General Office Expenses	154,974	15,059	14,760	184,793		184,793		184,793		21
22	Employee Benefits & Payroll Taxes			445,280	445,280		445,280		445,280		22
23	Inservice Training & Education			83	83		83		83		23
24	Travel and Seminar			10,268	10,268		10,268	(8,269)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,289	7,289		7,289		7,289		26
27	Other (specify):*			27,733	27,733		27,733	(27,733)			27
28	<b>TOTAL General Administration</b>	209,443	15,059	850,304	1,074,806	(51,465)	1,023,341	(47,928)	975,413		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,018,947	480,014	1,391,498	3,890,459	(148,621)	3,741,838	(47,928)	3,693,910		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number SAINT CLARE HOME

#0044024

Report Period Beginning: 10/01/2001 Ending: 09/30/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			286,947	286,947		286,947		286,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,645	21,645		21,645	(19,509)	2,136			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,826	6,826		6,826	(4,747)	2,079			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			315,418	315,418		315,418	(24,256)	291,162			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					97,156	97,156		97,156			39
40	Barber and Beauty Shops		62	22,158	22,220		22,220		22,220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		62	22,158	22,220	148,621	170,841		170,841			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,018,947	480,076	1,729,074	4,228,097		4,228,097	(72,184)	4,155,913			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning:

10/01/2001

Ending:

09/30/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,747)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(19,509)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(8,269)	24		19
20	Contributions	(248)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,237)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,485)	27		24
25	Fund Raising, Advertising and Promotional	(10,689)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,184)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (72,184)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

## SAINT CLARE HOME

ID# 0044024

Report Period Beginning: 10/01/2001

Ending: 09/30/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$	0	0
2		0	0
3		0	0
4		0	0
5		(4,747)	35
6		0	34
7		0	
8		0	
9		0	30
10			32
11		0	
12		0	
13		0	2
14		0	32
15		0	33
16		0	24
17		0	20
18		0	
19			24
20		(248)	27
21		0	
22		(1,237)	19
23		0	
24		(27,485)	27
25		(10,689)	20
26		0	0
27		0	0
28		0	0
29		0	0
30		0	0
31		0	0
32			
33		0	33
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(44,406)	

## Summary A

09/30/2002

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[illegible]

## Summary B

09/30/2002

## 09/30/2002

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2001 Ending: 9/30/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	OSF Health Care	xx		Working Capital							21,645	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 21,645	9	
	B. Non-Facility Related*												
10	Interest Income										(19,509)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (19,509)	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 2,136	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	SAINT CLARE HOME	COUNTY	PEORIA
---------------	------------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT

#### A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Index Number	Property Description	Total Tax	

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

33,800

B. General Construction Type:

Exterior

Brick/Wood

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 224,000	1
2					2
3	TOTALS			\$ 224,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98				\$ 2,682,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Smoke Detector			1999	1,932						9
10	Call Light System			1999	16,785						10
11	Sewage Ejector Pump			1999	3,800						11
12	Door Alarm System			1999	1,275						12
13	Chapel Renovation			1999	1,760						13
14											14
15	Wallpaper/Paint --Remodel Hallways			2000	45,058						15
16	Heat / Cool Pump--Rooftop A/C			2000	8,790						16
17	Corridor Renovation			2000	19,472						17
18	Cubicle Curtains			2000	4,020						18
19	Flooring -- Hallways			2000	45,048						19
20	Rooftop A/C Units			2000	328,932						20
21	Window Treatments			2000	7,221						21
22	Sign			2000	720						22
23	Chapel Renovation			2000	32,210						23
24	Smoke Detectors			2000	3,300						24
25											25
26	Wallpaper/Paint --Remodel Hallways			2001	8,820						26
27	Door Alarm			2001	12,678						27
28	Auto Door Opener			2001	1,919						28
29	Vinyl Floor Coverings -- North and West Wing Rooms			2001	73,863						29
30	Vinyl Floor Coverings -- North and West Wing Rooms --Labor			2001	3,750						30
31	Rooftop A/C Units			2001	88,341						31
32	Flooring -- Hallways			2001	3,418						32
33											33
34											34
35	Book Depreciation					224,885		224,885		753,484	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Security Alarm System	2002	\$ 15,826	\$		\$	\$	37
38	Entry Doors	2002	22,435					38
39	Circulating Pump	2002	4,322					39
40	North Corridor Paint	2002	5,643					40
41	Wallpaper	2002	12,945					41
42	Window Treatments	2002	12,508					42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 3,469,291	\$ 224,885		\$ 224,885	\$ 753,484	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,469,291	\$ 224,885		\$ 224,885	\$	\$ 753,484	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,469,291	\$ 224,885		\$ 224,885	\$	\$ 753,484	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 470,536	\$ 62,062	\$ 62,062	\$		\$ 274,247	71
72	Current Year Purchases	48,042						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 518,578	\$ 62,062	\$ 62,062	\$		\$ 274,247	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,211,869	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 286,947	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,947	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,027,731	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,079 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ \_\_\_\_\_

13. /2004 \$ \_\_\_\_\_

14. /2005 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		879		879
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 879	\$	\$ 879
10	SUM OF line 9, col. 1 and 2 (e)	\$ 879			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 56,272	\$		\$ 56,272	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			25,136			25,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			71,224			71,224	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				91,715		91,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				5,441			5,441	13
14	TOTAL			\$		\$ 158,073	\$ 91,715		\$ 249,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 455,329	\$	1
2	Cash-Patient Deposits	2,970		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	514,270		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,540		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,004,109	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	3,466,969		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	529,324		16
17	Accumulated Depreciation (book methods)	(1,027,731)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,192,562	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,196,671	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 82,012	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,970		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,459		30
31	Accrued Taxes Payable (excluding real estate taxes)	(18)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 276,423	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 276,423	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,920,248	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,196,671	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,213,509	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,213,509	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(293,261)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (293,261)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 3,920,248	24 *

\* This must agree with page 17, line 47.



**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,106,014	1
2	Discounts and Allowances for all Levels	(711,219)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,394,795	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,619	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 334,619	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	30,578	12
13	Barber and Beauty Care	23,309	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,677	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 185,071	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	842	24
25	Interest and Other Investment Income***	19,509	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20,351	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,934,836	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	810,474	31
32	Health Care	2,005,179	32
33	General Administration	1,074,806	33
	<b>B. Capital Expense</b>		
34	Ownership	315,418	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	22,220	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,228,097	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(293,261)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (293,261)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning: 10/01/2001

Ending:

09/30/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	1,992	2,080	\$ 48,040	\$ 23.10	1
2	2,306	2,491	49,992	20.07	2
3	8,351	8,940	178,503	19.97	3
4	17,919	20,381	324,694	15.93	4
5	56,592	61,948	643,239	10.38	5
6	100	100	879	8.79	6
7					7
8	3,392	3,973	51,065	12.85	8
9					9
10	5,341	6,169	55,855	9.05	10
11	2,224	2,310	27,112	11.74	11
12					12
13					13
14					14
15	20,082	21,845	218,866	10.02	15
16					16
17	4,218	4,436	62,359	14.06	17
18	11,655	13,162	113,551	8.63	18
19	3,348	3,861	35,349	9.16	19
20	2,080	2,080	54,469	26.19	20
21					21
22					22
23					23
24	11,235	12,003	154,974	12.91	24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34	150,835	165,779	\$ 2,018,947 *	\$ 12.18	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35		\$ 0		35
36		3,600		36
37		375		37
38				38
39		550		39
40				40
41				41
42				42
43				43
44				44
45		2,475		45
46				46
47				47
48				48
49		\$ 7,000		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$ 36,873		50
51		97,089		51
52		110,667		52
53		\$ 244,629		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Pete Bolt	Administrator	0	\$ 54,469	Workers' Compensation Insurance	\$ 12,441	IDPH License Fee	\$ 0				
				Unemployment Compensation Insurance	(4,614)	Advertising: Employee Recruitment	4,980				
				FICA Taxes	154,449	Health Care Worker Background Check (Indicate # of checks performed 25 )	224				
				Employee Health Insurance	219,121	Central Office Allocation					
				Employee Meals		Promotional Advertising	6,121				
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	4,568				
				Employee Hepatitis Vaccine	0	Dues and Subscriptions	7,164				
				Employee Benefits -	63,883	License and Fees	629				
				Employee Benefits - central office							

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number SAINT CLARE HOME

STATE OF ILLINOIS

# 0044024

Report Period Beginning: 10/01/2001

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 7,541
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not complete as of this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

[illegible]